INFORMATIONAL LETTER NO. 988

TO: Iowa Medicaid Physician, Dentist, Advanced Registered Nurse Practitioner, Therapeutically Certified Optometrist, Podiatrist, Pharmacy, Home Health Agency, Rural Health Clinic, Clinic, Nursing Facilities, Community Mental Health Center, Residential Care Facility, ICF MR State and Community Based ICF/MR Providers

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

DATE: February 9, 2011

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: March 14, 2011

1. **New Drug Prior Authorization Criteria-** See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

   - **Buprenorphine (Butrans™) Transdermal System:** Prior authorization is required for Butrans™. Payment will be considered when the following criteria are met: 1) Previous trials and therapy failures at a therapeutic dose with a preferred long acting morphine sulfate product and methadone. The preferred trials must allow for adequate dose titration and show use of a short acting narcotic for breakthrough pain. 2) A trial and therapy failure with fentanyl patch at maximum tolerated dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. *Use Buprenorphine (Butrans™) Transdermal System PA Form.*
   - **Dalfampridine (Ampyra®):** Prior authorization is required for dalfampridine (Ampyra®). Payment will be considered under the following conditions: 1) For patients that have a gait disorder associated with MS. 2) Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3) Additional prior authorizations will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate or severe renal impairment. *Use Dalfampridine (Ampyra®) PA Form.*
   - **Extended-Release Alpha$_2$ Agonists:** Prior authorization is required for extended-release alpha$_2$ agonists. Payment will be considered for patients when the following is met: 1) The patient has a diagnosis of ADHD and is between 6 and 17 years of age; and 2) Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3) Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine

stimulant; and 4) Previous trial and therapy failure at a therapeutic dose with atomoxetine (Strattera®). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. *Use Extended-Release Alpha$_2$ Agonists PA Form.*

- **Sodium Oxybate (Xyrem®):** Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline. 2) A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant. 3) Requests for patients with a prior history of substance abuse, concurrent use with a sedative hypnotic, or a semialdehyde dehydrogenase deficiency will not be considered. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. *Use Sodium Oxybate (Xyrem®) PA Form.*

2. **Changes to Existing Prior Authorization Criteria-** *Changes are italicized*. See complete prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

   - **Biologicals for Arthritis:** *Payment will be considered following an inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used in combination. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline). The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Upon an unsuccessful methotrexate trial, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.*
   - **Modified Formulations:** *Payment for a non-preferred isomer, prodrug, or metabolite will be considered when the following criteria are met: 1) Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. The required trials may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.*

     Payment for a non-preferred alternative delivery system will only be considered for cases in which the use of an alternative delivery system is medically necessary and

there is a previous trial and therapy failure with a preferred alterative delivery system if available.

- **Nonsteroidal Anti-Inflammatory Drugs:** Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs *(nsaids)* and COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs *or COX-2 inhibitors.* 1) Requests for a non-preferred nsaid must document previous trials and therapy failures with *three* preferred nsaids. 2) Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with *three preferred nsaids,* two of which must be a preferred COX-2 preferentially selective nsaid. 3) *Requests for a non-preferred topical nsaid must document previous trials and therapy failures with three preferred nsaids. The trials must include two preferred COX-2 preferentially selective nsaids and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary.4) Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.*

3. **Updated Preferred Drug List (PDL):** A new version of the PDL has been implemented. This updated version includes linked prior authorization (PA) forms and hover comments. Please be aware, not all drugs requiring prior authorization will have a linked PA form. Notably, the biologicals, non-preferred drugs without clinical PA criteria, and non-preferred brand name drugs will not have the required PA form(s) linked. All PA forms will continue to be available on the website www.iowamedicaidpdl.com under the PA Forms link.

4. **POS Billing Issues:**
   a). **Proper Billing of Synagis® and flu vaccines:** As a reminder, Synagis® 50mg Injection and all flu vaccine injections should be billed as 0.5

5. **Requests for travel or vacation medications:** Requests for travel or vacation medication(s) should be planned well in advance of the departure date. The pharmacy can process the first months' prescription(s) as usual, and then may call the Point of Sale (POS) Helpdesk at 877-463-7671 or 256-4608 (locally) to obtain up to a one month supply of medication(s) to total up to a 60 day supply of medication(s). Exceptions to Policy will not be granted if other sources for payment are available.

6. **DUR Update:** The latest issue of the Drug Utilization Review (DUR) Digest is located at the Iowa DUR website, www.iadur.org, under the "Newsletters" link.

We encourage providers to go to the website at **www.iowamedicaidpdl.com** to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization Helpdesk at 877-776-1567 or 515-256-4607 (local in Des Moines) or e-mail info@iowamedicaidpdl.com